

## Juridification, medicalisation and the impact of EU law: patient mobility and the allocation of scarce NHS resources

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## **JURIDIFICATION, MEDICALISATION AND THE IMPACT OF EU LAW: PATIENT MOBILITY AND THE ALLOCATION OF SCARCE NHS RESOURCES**

### **I. INTRODUCTION**

There has been a steady growth in the European Union's (EU) competence in relation to health care in recent years.<sup>1</sup> One aspect of the EU's involvement in this area has been the objective of liberalising the provision and receipt of health care across Member States so that, on the one hand, health care providers are able to offer their services in other Member States and, on the other, individuals may, assuming certain conditions are satisfied, travel to another Member State to access health care. This liberalisation, which is designed to extend to health care the operation of the internal market and competition rules, has given rise to a voluminous literature.<sup>2</sup> Within this, a recurring theme is the potential impact of what Szyszczak calls 'the

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<sup>1</sup> For an indication of the extent of the EU's legal jurisdiction in health care matters, and the nature of its impact on domestic law, see T Hervey and JV McHale, 'Law, Health and the European Union' (2005) 25 L.S. 228, and T Hervey and JV McHale, *Health Law and the European Union* (Cambridge: CUP, 2004).

<sup>2</sup> See, for example, C Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity' (2006) 43 C.M.L.R. 1645; C Newdick, 'The European Court of Justice, Trans-national Health Care, and Social Citizenship – Accidental Death of a Concept?' (2008-2009) 26 *Wisconsin International Law Journal* 844; Jost et al, 'The Role of Competition in Health Care: A Western European Perspective' (2006) 31 *Journal of Health Politics, Policy and Law* 687; A Cygan, 'Public Healthcare in the European Union: Still a Service of General Interest?' (2008) 57 I.C.L.Q. 529; and JW van de Gronden et al (eds.), *Health Care Law and EU Law* (The Hague: TMC Asser Press, 2011).

liberalisation of public welfare markets' upon the so-called 'European social model'.<sup>3</sup> In the context of health care, this analysis manifests itself in discussions concerning the relative effect of liberalisation on the nature of European health care systems – which have traditionally been founded upon principles of equity and solidarity. To what extent will liberalisation dilute, or even eradicate, these 'social' principles? Is a movement towards establishing EU citizens' rights to access health care across the EU supportable; or, as Newdick asks: '[I]s this individualistic view of health care rights mistaken and likely to damage the sense of social solidarity essential to any public, social welfare system[?]'.<sup>4</sup> Alternatively, might, as Ross suggests in his analysis of the *BUPA* case,<sup>5</sup> the social values associated with the European social model be reflected in EC competition rules, such that market principles do not invariably succeed in trumping those of solidarity?<sup>6</sup> These are interesting and important questions that go to the heart of the EU's desired value base in the context of health care. As such, what they have in common is a normative focus – that is, they revolve around questions of values and principles and the striking of an appropriate balance between, or among, them. This normative approach is neatly illustrated in Hervey's discussion of the European social model:

In the context of health policy, such [European social model] values may include equality of access to health care and the determinants of good health, solidarity in health care financing, and regulation of economic activity as is necessary to protect and promote public health. Promoting the European social model is thus a fundamentally normative activity. As the European Union emerges as a 'non-state post-national polity', its actions having effects in ever increasing areas of economic, social and political life, the issue of what model of social regulation is chosen within the EU's legal order is of crucial significance in terms of the values that post-

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<sup>3</sup> See E Szyszczak, 'Legal Tools in the Liberalisation of Welfare Markets' in U Neergaard et al (eds), *Integrating Welfare Functions into EU Law: From Rome to Lisbon* (Copenhagen: DJØF Publishing, 2009) 279.

<sup>4</sup> Newdick, 'Citizenship, Free Movement and Health Care', *op. cit.*, 1645.

<sup>5</sup> T289/03 *British United Provident Association Ltd (BUPA) v. Commission of the European Communities* [2005] ECR II-741 (CFI).

<sup>6</sup> M Ross, 'A Healthy Approach to Services of General Economic Interest? The BUPA Judgment of the Court of First Instance' (2009) 34 *European Law Review* 127.

national polity seeks to uphold.<sup>7</sup>

While recognising the importance of normative questions, this article's focus is different. For, rather than analysing what the desired balance of values and principles should be in the EU's emerging jurisdiction in the field of health care, it considers the potential consequences of this jurisdiction for the relationship between law, medicine, politics, and the economy in the context of the welfare state – specifically the National Health Service (NHS). In order to do so, it takes the European Court of Justice's (ECJ) ruling in *Watts* as a case study.<sup>8</sup> There has, of course, been much commentary on the *Watts* case.<sup>9</sup> What this article seeks to do, however, is to shift the analysis of this case in three ways. First, and as indicated, it moves the discussion away from normative concerns to focus, instead, on other issues – issues revolving around what might be called the political and the economic – that have received much less coverage in the existing literature. Secondly, it draws the analysis of the case directly into the realm of medical and health care, rather than EU, law by placing it within the context of some of the debates and concerns that have been central to those working within the sphere of medical and health care law. This is important as the vast majority of the analysis of *Watts* has been undertaken by EU lawyers. Finally, and related to this, it deploys social theory and analysis – specifically, Jürgen Habermas's work on juridification and Ivan Illich's reflections on medicalisation – to advance a novel way of thinking through the *Watts* case and its implications for the role of law *vis-à-vis* a

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<sup>7</sup> TK Hervey, 'Mapping the Contours of European Union Health Law and Policy' (2002) 8 *European Public Law* 69, 72.

<sup>8</sup> *R. (on the application of Watts) v. Bedford Primary Care Trust and Another* [2006] All ER (D) 220 (May).

<sup>9</sup> See, for example, J Hunt, 'Citizens' Rights to Receive Medical Treatment in Another EU Member State' (2006) 28 *Journal of Social Welfare & Family Law* 217; JV McHale, 'Rights to Medical Treatment in EU Law' (2007) 15 *Med. L. Rev.* 99; and Newdick, 'Citizenship, Free Movement and Health Care', *op. cit.*

number of key issues around the NHS. The description of the article's structure that follows will highlight some of these points and provide an indication of the arguments to be advanced.

The article begins by providing a detailed explanation of the notions of juridification and medicalisation, as developed in the work of Jürgen Habermas and Ivan Illich respectively. Those notions will form the framework through which the implications of the *Watts* case and the new EU patients' rights Directive – adopted in March 2011<sup>10</sup> – will be explored later in the article. Medical and health care lawyers will, of course, be familiar with the notion of medicalisation. Conveying a general sense of the colonisation by medicine and medical professionals of non-medical issues or problems, medicalisation, and especially its critique, can be thought to have been foundational in the development of medical and health care law. It formed, and continues to form, a target for medical and health care lawyers concerned to establish a legal system that works to reverse medicine's privilege over issues surrounding health and illness. The first section of the article, however, seeks to dig beneath this general idea of medicalisation in order to unearth some of its specific features. Focusing on Illich's work on the 'expropriation of health' in the 1970s, and what is argued here to be one example of its subsequent reception within medical law (the work of Sheila McLean), a picture emerges of medicalisation as synonymous with bureaucracy, de-individualisation, and expropriation. The power of individuals to manage their health and illness is supplanted by the bureaucratic machine of medicine. Medical and health care lawyers may not be as familiar with the other notion explained in the article's first section – namely, juridification. Nonetheless, it will be argued that

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<sup>10</sup> Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare (9 March 2011). This Directive will hereafter be referred to as 'the Directive'.

there are parallels between the phenomenon of juridification – as developed in Habermas’s work – and Illich’s and McLean’s understandings of medicalisation. In particular, it will become clear that the colonisation of non-legal and non-medical issues and problems by law and medicine, and the theme of the bureaucratic nature of the welfare state, are common features of the juridification and medicalisation described by these authors.

The following three sections set out the substantive material upon which the analysis in the penultimate section of the article is based. Thus, section two provides an overview of how the NHS fits within existing models of European health care systems. This serves to highlight the differences between ‘benefits-in-kind’ (like the NHS) and ‘refund’ systems. In particular, it helps to elucidate the more commoditised characteristics of the ‘refund’ system. The following section sets out the facts and rulings of the ECJ in the *Watts* case. In addition to this descriptive purpose, the section also identifies what is argued to be the political project underlying the ECJ’s ruling in the case. It is suggested that this project – the liberalisation of access to public health care services within the EU – gives rise to a number of questions and issues that are inherently political. Completing the description of the relevant law, section four of the article briefly describes and discusses the new EU patients’ rights Directive.

In the final substantive section of the article – section five – the notions of juridification and medicalisation described earlier are used to think through the *Watts* case and the Directive, and their various implications. This analytical framework has two distinct advantages. First, the themes of expropriation, bureaucracy, and a concern for individual freedom can be seen to be highly relevant to understanding EU law on patient mobility and its implications. For instance,

the theme of expropriation can help to shed light on how this area of EU law depoliticises important political questions and issues. It also enables an analysis of how the ruling in *Watts* might affect the nature of the relationship between law and politics that exists in the context of domestic cases involving challenges to the manner in which scarce NHS resources are allocated.

Secondly, the importance of the welfare state as a focal point for those authors' discussions of juridification and medicalisation facilitates engagement with the broader issue that might be taken to arise from *Watts* and the Directive – that is, the nature of the contemporary relationship between liberalisation, law, medicine, and the welfare state. This is, of course, a large topic and no attempt is made here to present an exhaustive analysis of it. The aim, rather, is to make a start in thinking about this broader issue – especially the structured nature of liberalisation and markets in the sphere of health care – by deploying the notions of juridification and medicalisation. In doing so, the argument advanced is that the move towards liberalisation and marketisation disclosed in EU law demands that we rethink some of the assumptions and foundations underlying those authors' analyses of juridification and medicalisation. In particular, the relevant law requires an extension of the notion of medicalisation as developed by, among others, Illich and McLean, beyond a concern for the moral-ethical question of the liberty of individuals *vis-à-vis* health and illness, to incorporate a focus on the relations between medicine and economic-related questions. Given the importance of medicalisation as a point of departure for critical analysis within medical law historically, expanding the understanding of this notion to incorporate such relations will enrich our understanding of how contemporary law fits into this picture.

Before commencing, it is important to stress that the argument advanced in this article is in no way intended to suggest that the ECJ's involvement in the field of health care is driven solely by the liberal tendencies inscribed in the principles of the internal market. It is clear that the ECJ sometimes places limits on the application of such principles by stressing alternative principles (solidarity, for instance) which are more in keeping with the EU's interest in paying due regard to social concerns. As Ross has noted: '[W]here features of social solidarity are sufficiently predominant in a national scheme such as social security, pensions or health care, the Court [ECJ] has been prepared to hold that the 'economic' aspect is displaced'.<sup>11</sup> This is especially true where competition rules are applied by the ECJ to health care matters.<sup>12</sup> The importance of acknowledging Member States' power to protect their national health care systems has, as we will see, also been re-emphasised in the recent patients' rights Directive. The objective here is thus neither to dispute this nor, as indicated above, to advance suggestions as to how the balance between the economic and the social might better be struck in the sphere of health care at the EU level. Rather, the purpose, at least in part, is, by way primarily of an analysis of *Watts*, to think through the relationship between the social and the economic in a different register to that encountered in the existing literature, such that the structures of liberalisation are identified as *including* social and public institutions – here, crucially, the legal and medical systems, and the NHS.

## II. JURIDIFICATION AND MEDICALISATION

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<sup>11</sup> M Ross, 'The Value of Solidarity in European Public Services Law' in M Krajewski et al (eds), *The Changing Legal Framework for Services of General Interest in Europe: Between Competition and Solidarity* (The Hague: TMC Asser Press, 2009) 81, 84. In the footnote to this quotation, Ross cites Case C-205/03 P *FENIN* [2006] ECR I-6295 to illustrate this point.

<sup>12</sup> An argument that can be found in E Szyszczak, 'Modernising Healthcare: Pilgrimage for the Holy Grail?' in Krajewski et al (eds), *ibid.* 191.



Juridification is a notion that emerged in legal and social theory to describe different types of phenomena. One of its most famous exponents – Jürgen Habermas – has described juridification as follows:

The expression 'juridification' refers quite generally to the tendency toward an increase in formal (or positive, written) law that can be observed in modern society. We can distinguish here between the *expansion* of law, that is the legal regulation of new, hitherto informally regulated social matters, from the *increasing density* of law, that is, the specialized breakdown of global statements of the legally relevant facts into more detailed statements. Otto Kirchheimer introduced the term [juridification] into academic discussion during the Weimar Republic. At that time he had in mind primarily the institutionalization of class conflict through collective bargaining law and labor law, and in general the juristic containment of social conflicts and political struggles.<sup>13</sup>

For Habermas, then, juridification has two features. The first denotes the widening of the application of law to cover areas previously regulated only informally; while the latter describes the process whereby 'legal norms ... tighten their hold ... by way of increasingly detailed normative standards ... [T]here is an observable tendency for these standards to become more detailed in their specification of the factual circumstances that are being legally regulated'.<sup>14</sup> Habermas explicates juridification by identifying four 'juridification thrusts' that have occurred since the seventeenth century. Here, only the last of these – the welfare state – will be discussed.<sup>15</sup>

According to Habermas, the development of the welfare state can 'be understood as the institutionalizing in legal form of a social power relation anchored in class structure.' – something that may be illustrated in, for example, the emergence of collective bargaining in the sphere of employment and the limits placed on the working day. The norms and regulations associated with the welfare state are meant to further what Habermas calls 'freedom-

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<sup>13</sup> J Habermas, *The Theory of Communicative Action – Volume 2: Lifeworld and System* (Cambridge: Polity, 1987), 357. Reference omitted. Emphasis in original.

<sup>14</sup> S Veitch et al, *Jurisprudence: Themes and Concepts* (Abingdon: Routledge-Cavendish, 2007), 217.

<sup>15</sup> His discussion of the other three juridification thrusts – the bourgeois state, the bourgeois constitutional state, and the democratic constitutional state – can be found at Habermas *op. cit.*, 358-61.

guaranteeing juridification’ – that is, they are intended to protect individuals against the consequences of the operation of the capitalist economy by, for instance, establishing a State pension or a health care system funded from the public purse. The essence of Habermas’s argument here is that the ‘freedom-guaranteeing juridification’ of the welfare state is ambivalent, such that it simultaneously guarantees freedom and takes it away. He argues that this arises not as a side effect of juridification, but ‘*from the form of juridification itself*. It is now the very means of guaranteeing freedom that endangers the freedom of the beneficiaries’.<sup>16</sup> Thus, addressing life-risks such as old age through the provision of a legal entitlement to a monetary benefit individualises these risks by creating legal subjects who pursue their private interests. Rather than guaranteeing freedom, Habermas suggests that this juridification of life-risks can result in the opposite, as claimants come increasingly to depend on the interventions of the bureaucratic state. Importantly, this system of individual legal entitlements ‘also has consequences for the readiness of solidaric communities to provide subsidiary assistance’.<sup>17</sup> This points more generally to the social effects of such juridification. For, in Habermas’s view, juridification amounts to a colonisation of the lifeworld of those who depend on the benefits of the welfare state.<sup>18</sup> It impacts negatively on the communicative structures of the lifeworld by, amongst other things, failing to pay due regard to the social conditions within which social questions and problems originate: ‘The situation to be regulated is embedded in the context of a life history and of a concrete form of life; it has to be subjected to violent abstraction, not

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<sup>16</sup> *Ibid.*, 362. Emphasis in original.

<sup>17</sup> *Ibid.*

<sup>18</sup> Cotterrell helpfully summarises Habermas’s concept of the lifeworld as follows: ‘The lifeworld is the environment of everyday social experience in which customs, cultures, moral ideas and popular understandings are formed and reproduced.’ See R Cotterrell, *Law, Culture and Society: Legal Ideas in the Mirror of Social Theory* (Aldershot: Ashgate, 2006), 25.

merely because it has to be subsumed under the law, but so that it can be dealt with administratively'.<sup>19</sup> Ultimately, this leads Habermas to note the:

*dilemmatic structure of this type of juridification* [which] consists in the fact that, while the welfare-state guarantees are intended to serve the goal of social integration, they nevertheless promote the disintegration of life-relations when these are separated, through legalized social intervention, from the consensual mechanisms that coordinate action and are transferred over to media such as power and money.<sup>20</sup>

It has been noted that while Habermas's notion of juridification is synonymous with a crisis of the legal system, this is not the only possible understanding of the phenomenon.<sup>21</sup> For juridification has also been viewed as a political, rather than a legal, problem. Habermas himself draws attention to this political understanding of juridification in the quotation at the beginning of this section, where he refers to Kirchheimer's use of juridification to refer to 'the juristic containment of social conflicts and political struggles'. Here, 'political disputes or problems are distorted by being made to fit legal categories' through 'the legal system appropriating, or juridifying, conflicts that should more properly be dealt with politically'.<sup>22</sup> Mathiesen sums up the political understanding of juridification, and its implications, succinctly as follows:

[J]urisprudence contains a peculiar potential to transform political questions of conflict into apparently neutral, technical and professional questions ... In parts this happens by the jurist's raising the fundamental legal question of whether there exists a 'legal authority' or 'legal basis' for given actions; in short, whether the actions are legal. Thereby the debate is transformed from being a clearly political debate – for and against a political standpoint – to being an exchange of opinions concerning the apparently neutral and unpolitical issue of whether legal authority or basis 'exists' ... [T]he debate is 'lifted' from the political to the professional-juridical level, the professional-juridical level being regarded as superordinate and therefore more 'elevated'.<sup>23</sup>

Another way of putting this would be to say that law depoliticises conflict. It transforms political questions and conflicts into questions of, and conflicts around, law, whether in the form of a

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<sup>19</sup> Habermas *op. cit.*, 363.

<sup>20</sup> *Ibid.*, 364. Emphasis in original.

<sup>21</sup> Veitch et al, *op. cit.*, 221.

<sup>22</sup> *Ibid.*, 222.

<sup>23</sup> T Mathiesen, *Silently Silenced: Essays on the Creation of Acquiescence in Modern Society* (Winchester: Waterside Press, 2004), 17.

search for the correct legal precedent or, as Mathiesen says, the appropriate legal basis for given actions. Legalising such questions and conflicts deprives them of their political quality, thereby diminishing the possibility for debate over fundamental issues, such as the values we wish to inform the nature of our social institutions. To deploy Mathiesen's phrase, law 'silently silences' the political.

Rather than juridification, it is medicalisation that has been the object of critical analysis for some medical lawyers. Indeed, it could be said that the critique of medicalisation has been instrumental in giving rise to the area of research that has come to be known as medical law. Like the second – political – form of juridification described above, it has been argued that the essence of medicalisation lies in the conversion of traditionally non-medical problems and issues – namely, health and illness – into medical ones. In a book that could be considered to have been influential in inspiring the critique of medicalisation within medical law, Ivan Illich criticises the power of medicine in modern society and what he calls its 'expropriation of health'.<sup>24</sup> Medicine, he argues, has developed a monopoly over health care and deprived citizens of their autonomous powers to manage their health: 'Society has transferred to physicians the exclusive right to determine what constitutes sickness, who is or might become sick, and what shall be done to such people'.<sup>25</sup> This 'threatens to destroy the environmental and cultural conditions needed by people to live a life of constant autonomous healing'.<sup>26</sup> What emerges as a core feature of Illich's understanding of medicalisation, then, is how medicine and medical professionals have expropriated or colonised the ability of individuals to care for

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<sup>24</sup> I Illich, *Limits to Medicine – Medical Nemesis: The Expropriation of Health* (Harmondsworth: Penguin, 1990 [1976]).

<sup>25</sup> *Ibid.*, 13-14.

<sup>26</sup> *Ibid.*, 14.

themselves where health is concerned. It is 'self-reliance', 'autonomy', 'personal growth', and 'personal responsibility' in the field of health care that are the casualties of medicalisation; to put it differently, a key component of medicalisation is its de-individualising quality.

As well as de-individualisation, Illich identifies the decoupling of medicine and morality as another feature of what he calls 'the medicalization of life'. Medical ethics have been supplanted by the technical, scientific nature of medicine – a supposed value-free discipline – and the courts and the law have done nothing to challenge this: 'The courts and the law, when they are not used to enforce the Aesculapian monopoly, are turned into doormen of the hospital who select from among the clients those who can meet the doctors' criteria'.<sup>27</sup> Aligned to this is the bureaucratic nature of what Illich defines as medicalisation. Like Habermas's theory of juridification, the needs of the bureaucratic and administrative state loom large in Illich's analysis:

Medicalization constitutes a prolific bureaucratic programme based on the denial of each man's need to deal with pain, sickness, and death ... Suffering, healing, and dying, which are essentially intransitive activities that culture taught each man, are now claimed by technocracy as new areas of policy-making and are treated as malfunctions from which populations ought to be institutionally relieved. The goals of metropolitan medical civilization are thus in opposition to every single cultural health programme they encounter in the process of progressive colonization.<sup>28</sup>

In Habermas's language, it could be said that this sort of medicalisation involves the bureaucratically driven colonisation by medicine of the lifeworld of individuals and the destruction of the cultural mechanisms and conditions historically developed to cope with, and manage, health and illness.

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<sup>27</sup> *Ibid.*, 55-6.

<sup>28</sup> *Ibid.*, 137-8. References omitted.

As mentioned, Illich's book, and the arguments about medicalisation within it, might be thought to have been influential in shaping some academic medical lawyers' focus on medicalisation as a key problem of, and for, law – not least as Illich envisaged the recognition of his desired return to autonomous action as being optimally secured via legal (and political) procedures.<sup>29</sup> Illich's influence in this regard can be seen, for instance, in Sheila McLean's *Old Law, New Medicine*.<sup>30</sup> In this book, McLean is critical of the ways in which not only 'human problems and human values become medicalised', but how the law is complicit in helping to produce this state of affairs. Through its deference to medicine and medical professionals, McLean argues, law sustains medicalisation and disenfranchises the individual as a result. Like Illich, then, McLean views medicalisation as constituting, on the one hand, an expropriation by medicine of human values and problems, and on the other, a process that de-individualises. This latter consequence amounts to a failure to respect the autonomy of patients and, specifically, to acknowledge their liberty to make decisions regarding their medical treatment. As with Illich, McLean's critique of medicalisation here resides in the failure to pay due regard to civil liberty – that is, freedom from interference (in one's body and in the decisions one wishes to take on the basis of one's personal value or belief system). In short, medicalisation prevents individuals being left alone to make decisions about medical treatment which will subsequently be respected by medical professionals. Rather than supporting this detrimental consequence by shoring up medicalisation, McLean argues that law should, if you like, initiate a process of de-medicalisation by deploying the language of human rights to the ends of recognising that illness

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<sup>29</sup> *Ibid.*, 270-1.

<sup>30</sup> S McLean, *Old Law, New Medicine: Medical Ethics and Human Rights* (London: Pandora, 1999). Further examples of the importance of medicalisation as a focus for critical analysis within medical law can be found in the work of Ian Kennedy (*Treat Me Right: Essays in Medical Law and Ethics* (Oxford: Clarendon Press, 1988)) and Sally Sheldon (*Beyond Control: Medical Power and Abortion Law* (London: Pluto, 1997)).

is a human, rather than a medical, phenomenon, and of upholding individual self-determination.

What are the key points to be extracted from this brief tour of juridification and medicalisation?

From the authors discussed here, these phenomena share two principal features. First, they capture processes of expropriation in which problems, issues and conflicts are torn from their original settings or conditions and made subject to law and/or medicine. Various consequences flow from such processes, including the denial of freedom; the disregard for the social and cultural conditions and relations of what Habermas calls the lifeworld; and the depoliticisation of fundamental political issues, questions, and conflicts. Secondly, juridification and medicalisation are closely related to what is taken to be the bureaucratic nature of the welfare state. Underlying the analyses of juridification and medicalisation set out here is, in effect, a critique of the welfare state for its perceived technocracy, scientism, and soullessness. The medicine and law of the welfare state are thought to function in such a way as to deprive the individual of power and freedom, and to ensure, instead, the efficient workings of an overweening bureaucratic state. For McLean and Illich, at least, law possesses the ability and characteristics to transform the negative aspects of medicalisation and juridification into a legal system that promotes individual freedom through the discourse of rights. Whereas Habermas is sceptical of the potential of the legal entitlements of the welfare state to guarantee freedom, McLean and Illich argue that rights – in McLean's case *human* rights – constitute the best method of reversing the phenomenon of medicalisation and, thus, of recognising the autonomy, personal growth and responsibility so comprehensively effaced by the type of medicine and law characteristic of the bureaucratic welfare state.

Later in the article, the notions of juridification and medicalisation will be deployed as lenses through which to comprehend the *Watts* ruling, the recent Directive, and their implications – especially those relating to the relationships between, on the one hand, law and politics where access to health care is concerned, and, on the other, the welfare state and the market. First, however, it is necessary to describe the relevant substantive material upon which this analysis is to be based. That is the objective of the following three sections.

### III. THE NHS AND MODELS OF EUROPEAN HEALTH CARE SYSTEMS

The NHS is a public, or social, health care system, funded via general taxation. Like most other European health care systems, its scope is universal in that it covers the entire national population (those who are ‘ordinarily resident’ in the UK). Its guiding principle, frequently reiterated by UK Governments, is that access to medical treatment and health care services is based on clinical need and not the ability to pay.<sup>31</sup> The NHS, however, differs in important respects from some other European social health care systems.<sup>32</sup> Unlike what is called the ‘insurance’ model, in which social health care is funded through contributions employees and employers make to specific insurance funds, as noted the NHS is directly financed by the state through taxation. Its underlying foundation is thus citizenship, rather than participation in a particular trade or profession.<sup>33</sup> Moreover provision of health care within tax-based systems

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<sup>31</sup> For the latest reassertion of this principle, see the current Coalition Government’s White Paper, Department of Health, *Equity and Excellence: Liberating the NHS* Cm 7881 (London: The Stationery Office, 2010), 3.

<sup>32</sup> The following narrative detailing these differences relies on the description of European health care systems in V Hatzopoulos, ‘Health Law and Policy: The Impact of the EU’, in G de Búrca (ed), *EU Law and the Welfare State* (Oxford: OUP, 2005), 116-19.

<sup>33</sup> It should be noted that some authors have discussed the potential ramifications for the notion of citizenship of the EU’s increased involvement in matters of health care. For one such discussion, see E Szyszczak, ‘Legal Tools in



like the NHS is predominantly public – that is, it is delivered by health care professionals directly employed by the state.<sup>34</sup> This differs from provision under ‘insurance’ systems, where, because of the variety of insurance funds in existence, both public and private health care providers are routinely involved in delivering social health care.

A further, notable distinction exists in the context of European health care systems. This relates to the mode of receiving health care benefits. The NHS operates on the basis of a ‘benefits-in-kind’ system. Here, patients receive medical treatment from specific providers – either public or private (the latter having a contract with the state to provide social health care) – without having to pay for it up front. While the cost of treatment delivered by public bodies is settled directly by the state, in the case of private providers, usually a flat annual fee is payable, together with ‘a fee per capita of patient treated, plus actual expenses incurred’.<sup>35</sup> As Hatzopoulos notes: ‘In this system the choice of patients is more restricted ... Healthcare under this system is seen more as a public good to which access should be ensured in all circumstances and less as a commodity or good for which the consumer/patient may have a say’.<sup>36</sup> The ‘refund’ system, on the other hand, offers patients greater choice, as they may elect to receive their treatment from any public or private health care provider, irrespective of the cost. Under this system, patients initially pay for their treatment and then claim reimbursement of it. In contrast to the benefits-in-kind system, the extensive choice characteristic of the refund

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the Liberalisation of Welfare Markets’, *op. cit.* 282-7. While interesting, this article will not engage with the question of citizenship.

<sup>34</sup> Although a greater role for private and voluntary providers of health care within the NHS has been created by successive UK governments. For the latest proposals to widen the range of providers in England, see Department of Health, *op. cit.*

<sup>35</sup> Hatzopoulos, *op. cit.*, 117.

<sup>36</sup> *Ibid.*

system renders it more compatible with a commoditised understanding of health care, in which the patient might better be viewed as a consumer selecting treatment(s) from a variety of health care providers.

It is worth stressing that such a commoditised vision of health care directly contradicts the founding principles of the NHS. As well as making clinical need and not the ability to pay the key determinant of access to health care services, at its inception the NHS encapsulated a more general vision of the nature of human relations. In the first instance, this was apparent in Beveridge's blueprint for the establishment of a welfare state within the UK.<sup>37</sup> There, guided by the objective of abolishing what he termed the five 'Giant Evils' of Want, Idleness, Squalor, Ignorance, and Disease, Beveridge noted that a key plank of this task had to be the 'establishment of comprehensive health and rehabilitation services' by means of a national health service which would provide to all citizens 'medical treatment covering all requirements ... and post-medical rehabilitation treatment ... for all persons capable of profiting by it'.<sup>38</sup> This health service was to be part of 'a new type of human institution [State insurance]', the 'social' basis of which implied 'that men stand together with their fellows'.<sup>39</sup> As John Harrington has noted, the architect of the NHS, Nye Bevan, was to entrench and flesh out this vision of the UK's new health care system.<sup>40</sup> Not only was health care not to be seen as simply another commodity to be bought and sold; it was also designed to be a vehicle for the promotion of more fundamental human values such as altruism and solidarity. Bevan thought that these values would be enhanced by, for instance, removing doctors from the disciplines of wage

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<sup>37</sup> See Sir William Beveridge, *Social Insurance and Allied Services* Cm 6404 (London, 1942).

<sup>38</sup> *Ibid.*, 8 and 11.

<sup>39</sup> *Ibid.*, 13.

<sup>40</sup> J Harrington, 'Visions of Utopia: Markets, Medicine and the National Health Service' (2009) 29 L.S. 376, 383-85.

labour. Medical work was to be divorced from the pursuit of profit characteristic of other lines of employment, with doctors being judged by the extent to which they practised in accordance with the accepted standards and ethics of the medical profession. Bevan's overriding purpose was to ensure that health care became what Harrington has described as 'a zone of non-commodified human relations'.

The manner in which patients gain access to public health care services within the UK reflects this non-commoditised idea of the NHS and its underlying values of altruism and solidarity. This can be seen in the framework that has emerged to allocate health care resources within the NHS in conditions where demand for access to treatment outstrips supply. The inevitable rationing of resources that this reality entails has resulted in the operation of the 'waiting list' system, whereby, on the basis of an assessment of general clinical priorities, local health authorities set times within which individuals can expect to receive treatment for their specific illnesses.<sup>41</sup> Rather than access to medical treatment being determined by individual demand and choice, such a system seeks to implement a measure of fairness by ensuring that those with the most pressing clinical needs obtain access to treatment first. As Newdick has noted, this displays elements of solidarity, in the sense that 'the needs of the individual are balanced with those of the community'.<sup>42</sup> Decisions about whether particular individuals ought to be given access to NHS treatment must be made by taking due account of both the scarcity of resources and the needs of others. This approach is supported by the benefits-in-kind nature of the NHS, which, as noted above, does not involve individuals paying up front for their

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<sup>41</sup> The operation of waiting lists is not the only means of rationing scarce health care resources. For a discussion of other mechanisms, including rationing by denial and selection, see K Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge: CUP, 2007), Ch. 3.

<sup>42</sup> Newdick, 'Citizenship, Free Movement and Health Care', *op. cit.*, 1652.

treatment. Moreover, it is necessary to emphasise the inherently *political* nature of allocating scarce health care resources. At one level, this reflects the fact that it is the national government of the day that determines the annual budget of the NHS. How much is devoted to health care each year must be decided in the context of overall government spending and requirements. At another level, it means that, democratically, the decision as to how scarce resources are allocated rests with the Government and, more specifically, with those, such as primary care trusts, with the authority to make such decisions in practice.<sup>43</sup> We will return to this political aspect of the allocation of NHS resources and, more specifically, the consequences of EU law for its relationship to law domestically, later. First, it is necessary to set out the facts of *Watts*, its holdings, and what, for the purposes of this article, are its relevant points.

#### IV. R (ON THE APPLICATION OF WATTS) V. BEDFORD PRIMARY CARE TRUST AND ANOTHER<sup>44</sup>

In 2006, the ECJ handed down its ruling in the *Watts* case. The case involved a Mrs. Yvonne Watts who travelled to France, had a hip replacement operation, paid for it, and on her return, claimed to be entitled to reimbursement from NHS funds. Under EU law, reimbursement for hospital treatment received in another EU Member State is possible, but only if you have received prior authorisation from your local primary care trust. While Mrs. Watts had sought such authorisation, it had been refused. Her claim for the cost of the operation was dismissed by the Secretary of State for Health and her subsequent application for judicial review of the

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<sup>43</sup> It should be noted that the UK's Coalition Government plans to scrap primary care trusts, their purchasing and allocative powers being transferred to GP consortia. See Department of Health, *op. cit.*

<sup>44</sup> [2006] All ER (D) 220 (May)

Secretary of State's decision failed. Nonetheless, several important legal questions revolving around EU law arose in the course of the case, and these were referred by the Court of Appeal to the ECJ for preliminary rulings.

One of the key questions was this: Given the scarcity of NHS resources, do patients have a right to jump the waiting list queue by going to another Member State to obtain hospital treatment at the cost of the NHS; and, if so, on what basis can they exercise this right? The ECJ ruled that patients did have such a right, assuming they were enduring 'undue delay' for their treatment within the NHS. If they were suffering undue delay, then the local primary care trust must authorise treatment abroad. But, how does one determine whether or not undue delay exists? The UK Government argued that as long as Mrs. Watts would undergo her operation within the NHS waiting list time for hip operations, there would be no undue delay in treating her. The ECJ, however, ruled that the measure of undue delay could not simply be waiting list times or the argument of limited NHS resources. Rather, undue delay was to be determined by way of 'an objective medical assessment of the patient's medical condition, the history and probable course of his illness, the degree of pain he was in and/or the nature of his disability at the time when the request for authorisation was made or renewed'. So, if the waiting time for an operation on the NHS is 12 months, but an 'objective medical assessment' of a patient's clinical needs determines that this exceeds an acceptable waiting period for this particular patient, there will be undue delay and treatment abroad must be authorised. As Mrs. Watts had been deemed by the domestic court at first instance not to have suffered undue delay, she was not entitled to recover the cost of her hip operation.

*Watts* also confirmed that A49 of the EC Treaty (now A56 TFEU) on freedom to provide (and, by extension, to receive) services extended to health care services and covered the NHS. This added a further legal route for patients wishing to obtain hospital treatment abroad at the expense of the NHS. Previously, the only avenue lay under A22 of Council Regulation (EEC) 1408/71. Assuming the treatment sought abroad is one of the benefits provided by the NHS and that the patient cannot receive this treatment via the NHS ‘within the time normally necessary for obtaining the treatment in question [in the NHS] taking account of his current state of health and the probable course of his disease’, A22 obliges the patient’s local primary care trust to authorise the treatment abroad. Here, the treatment must be state-provided and its costs are settled directly between the home and host Member States. The application of A49 [A56 TFEU] in this context broadens the legal basis of the right to obtain hospital treatment elsewhere in the EU by making it an aspect of the general freedom to provide (and receive) services. Assuming the patient is suffering ‘undue delay’ (defined above) within the NHS, the local primary care trust must authorise the request for treatment to be obtained abroad. Under A49 [A56 TFEU], patients may choose to obtain their hospital treatment from any foreign health care provider (whether state or private). The patient pays the overseas provider for the treatment up front and then claims reimbursement of the cost from the NHS. The amount recovered may not exceed the cost of the treatment, had it been performed within the NHS.

The three arguments advanced by the UK Government in *Watts* provide a route into the types of issues with which this article is concerned.<sup>45</sup> The first argument was that allowing NHS

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<sup>45</sup> The UK, along with the Irish, Government had made these arguments, or representations, in an earlier case called Case C-385/99 *Muller-Fauré and Van Riet v. Onderlinge Waarborginaatschappij* [2003] ECR I-4503

patients to travel to another Member State to receive hospital treatment earlier than they would obtain it on the NHS would adversely affect the manner in which scarce health care resources were allocated within the NHS – that is, through the waiting list system. This would risk causing financial imbalance within the NHS, as refunding patients who had been treated abroad would reduce the resources available for those in need of urgent treatment at home, thereby compromising the NHS's ability to fulfil its role as a provider of adequate levels of health care. The Secretary of State argued that waiting lists should be the appropriate measure of whether patients would suffer undue delay in being treated, as these waiting times and the priorities inherent in them were already based on clinical judgments about medical need and priorities. If patients were able to travel to another Member State to receive treatment early, these judgments would be rendered ineffective.

Secondly, the Secretary of State contended that uncertainty would be created for the NHS by the impossibility of predicting both how many patients would seek treatment abroad and how many from abroad would travel to the UK for treatment. The impact of liberalisation on each UK hospital would no doubt differ, causing problems in allocating resources. Finally, the Secretary of State argued that, owing to the specific nature of the NHS – including the fact that it operated a benefits-in-kind system and was a non-profit-making body – it could not be deemed to constitute a 'service' under Article 50 of the EC Treaty (now A57 TFEU), as its services were not 'provided for remuneration'. Consequently, it could not be subject to the freedom to provide (and receive) services provision in Article 49 of the EC Treaty [A56 TFEU]. This contrasted with the health care systems of some other EU Member States, such as France (where Mrs. Watts received her treatment), which display the necessary element of

remuneration in the form of the refund system described earlier (patients paying for treatment up front and claiming reimbursement of the costs).

What the Secretary of State's arguments point to is not only a defence of the non-commoditised, collective nature of the NHS based on waiting lists, but also an assertion of the political right of Member States legitimately to determine the characteristics of their national health services and not have the principles upon which these are based undermined. Thus, in accordance with this understanding of the NHS, the role of doctors and their clinical judgments of medical priorities have a collective objective, which is directed at allocating scarce health care resources in a manner fairest to the community. Waiting lists are the outcome of these clinical judgments and ought, in the Secretary of State's view, to act as the measure of whether patients suffer undue delay within the NHS. Moreover, the idea of paying for medical treatment up front and having to claim it back – as is the case under the 'refund' system – is alien to the NHS, its absence resulting from a political determination to preserve the founding principle of the NHS that access to treatment is based upon clinical need rather than the ability to pay.

The response of the ECJ to the Secretary of State's arguments directly challenges both the principles of the NHS and the political claim to legitimacy underlying those arguments. For while the ECJ stressed in its ruling that its interpretation of the relevant EU law did not mean that budgetary considerations in the planning of NHS waiting lists were irrelevant when determining a Member State's obligation to reimburse the costs of a patient's hospital treatment abroad, such considerations are subordinate in its judgment to the fundamental role played by objective assessments of patients' individual medical conditions. Thus, at one point



the ECJ speaks of ‘the national competent authorities’ power to manage the available hospital capacity in their territory by the use of waiting lists [not being undermined by the ruling in *Watts*], *provided that* the existence of such lists does not prevent the taking account in each individual case of the medical circumstances and the clinical needs of the person concerned when he requests authorisation to receive hospital treatment in another Member State at the expense of the system with which he is registered’.<sup>46</sup> In other words, EU law will be liable to undermine this ‘power to manage the available hospital capacity’ should the clinical needs of individual patients not be taken into account. The recognition by the ECJ of the ‘overriding national objectives relating to management of the available hospital capacity, control of health expenditure and financial balance of social security systems’ is thus not, as it claims, balanced against ‘the objective of the free movement of patients’ but dependent on the national authority providing for the latter by ensuring objective medical assessments of individual patients are conducted. Moreover, the Secretary of State’s contention that the NHS did not fall within the meaning of a ‘service’ under Article 50 of the EC Treaty [A57 TFEU], meaning Article 49 [A56 TFEU] did not apply, was evaded by the ECJ, as it said there was no need to determine whether or not this was the case. Article 49 [A56 TFEU] applied where a person whose state of health necessitated hospital treatment went to another Member State and there received such treatment for consideration; in this context, the resolution of the ‘service’ status of the NHS was superfluous. The NHS was therefore subject to A49 of the EC Treaty [A56 TFEU].

These rulings challenge the underlying nature and values of the NHS inherent in the Secretary of State’s arguments. One obvious example of this lies in the potential of the ECJ’s ruling to

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<sup>46</sup> [2006] All ER (D) 220 (May), para. 75. Emphasis added.

defeat the planning aspect of the NHS and its collective goal of ensuring fairness of access to medical treatment amongst members of the national population via the operation of waiting lists. As noted above, this is because findings of undue delay may result in those patients who require urgent hospital treatment having to wait longer for it, as the resources assigned for their treatment are used, instead, to reimburse less urgent cases which have received authorisation to be treated elsewhere in the EU. This results, at least partially, from what might be called the individualisation of clinical judgment that plays such an important part in the ECJ's ruling. For while clinical judgment in the context of scarce NHS resources functions as a way of determining the timing of access to treatment domestically, based upon a system of medical priorities at a macro level (through the construction of waiting lists), for the purpose of accessing treatment within the EU, the ECJ demands that clinical judgment focus, rather, on *each individual patient* and his or her medical condition and surrounding circumstances. This individualisation of clinical judgment has the potential to upset the planning decisions reflected in waiting lists and to divert scarce resources away from those who have a more urgent need, but, for whatever reason, have not sought prior authorisation for treatment abroad.

But as well as being at odds with the Secretary of State's arguments regarding the NHS's nature and guiding values, the rulings in *Watts* have implications at what might be described as the political level. It is suggested that these implications flow from a concrete political project emerging at the EU level to ensure what, as noted earlier, Szyszczak calls 'the liberalisation of public welfare markets'. It is important to re-emphasise that the ECJ's rulings across the field of health care do not point invariably in the direction of establishing a blanket liberalisation of health care services policy within the EU. Nevertheless, *Watts* and other cases on patient

mobility do provide evidence of the ECJ's desire to promote liberalisation and the development of the internal market in the sphere of health care. As such, it is important to analyse how this project is being established through EU law and the types of consequences accompanying it. This analysis will take place in the penultimate section of this article and will be conducted through the analytical framework of juridification and medicalisation set out earlier. It is worth, however, briefly laying some of the groundwork for this analysis here.

One way into understanding this political project, and the framework being constructed to facilitate its realisation, is to consider it in terms of the flow of NHS resources. At the Court of Appeal stage in *Watts*, May LJ made the following observation:

[I]t is not immediately clear why a state-funded national health service should be required to fund those who provide medical services privately in other member states; nor why it should be required to do so at the expense of those who provide medical services privately within its own state. Nor is it comfortable to derive a potential obligation on a member state to provide larger resources to a publicly funded national health service from a principle designed to protect commercial service providers in other member states.<sup>47</sup>

As noted earlier, different types of social health care system exist across the EU. While the NHS can be thought to display strong 'public' characteristics, other systems, such as France, are more 'private' in nature, as patients can elect to receive treatment from a public or commercial health care provider and pay up front for their treatment (later seeking reimbursement from the relevant insurer). A crucial distinction that May LJ alludes to lies in the absence of a right within the NHS to be treated by a private health care provider at public expense. If this is not available to patients within the NHS, then why, May LJ asks, should it be so abroad, with the consequence that NHS resources are diverted to support commercial health care providers elsewhere in the EU? Moreover, May LJ queries why the need to protect such providers in

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<sup>47</sup> *R. (on the application of Watts) v. Secretary of State for Health* [2004] All ER (D) 349 (Feb), para. 103.

other Member States should act as the source of an obligation upon the UK Government to plough further money into the NHS to plug the gap created by this diversion of resources.

These questions are not answered by the ECJ in its ruling; rather, its response is simply to apply EU law with the objective of developing the EU internal market and the free movement of services. Irrespective of the nature of the health care provider (public/private), patients must be able to travel to other EU Member States to receive hospital treatment at a point in time when they should, on the basis of an objective medical assessment, have been entitled to obtain it at home. And irrespective of the makeup of individual Member States' social health care systems (taxation/insurance; benefits-in-kind/refund), each one must reimburse such hospital treatment. Otherwise, the internal market will not work. The upshot is that, even though NHS resources do not support private health care providers of hospital treatment at home by means of a patient entitlement to utilise their services, after *Watts*, they must nevertheless support them abroad. That is a fundamental condition of the liberalisation of hospital care services within the EU. As well as patients, national resources, funded in the case of the NHS from general taxation, must be free to flow across national borders within the EU – assuming the conditions surrounding 'undue delay' have been satisfied.

What emerges here is how this political project of liberalising access to hospital care services gives rise to inherently political questions and issues, including the following: Should taxpayers' money be diverted to support commercial health care providers in other EU Member States? Is this in the public interest? Is the impact of the *Watts* ruling upon the core principles underlying the NHS supportable? Given that the ECJ makes the recognition of Member States' power to

manage their hospital capacity through the use of waiting lists dependent on the existence of a system of assessment of *individual*, as opposed to collective, clinical need, does this not amount to a direct challenge to the political legitimacy of the Government, and primary care trusts, to determine the direction in which the scarce health care resources of the NHS flow?<sup>48</sup> These are questions that give rise to conflicts and debates over the shape our societies and its welfare institutions should take – conflicts and debates one might assume would be managed and conducted not only by the political institutions of Member States, but especially by those who pay their taxes. These questions and issues should, thus, be viewed as properly political ones. In order to think through the impact of the ruling in *Watts* on, *inter alia*, how these types of political questions and issues are managed by law, the relationship between law and politics where NHS resources are allocated in domestic cases, and the broader role of the contemporary welfare state *vis-à-vis* the market, recourse will be had to the notions of juridification and medicalisation described earlier. However, before this, it is necessary briefly to explain the provisions of the recently adopted EU patients' rights Directive that are relevant to this article and to consider what effect, if any, they have had on the ECJ's ruling in *Watts*.<sup>49</sup>

## V. THE EU PATIENTS' RIGHTS DIRECTIVE<sup>50</sup>

The first point to note about the Directive is its legal basis – A114 TFEU. The use of this Article, the purpose of which is to facilitate the harmonisation of laws in pursuit of the development of

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<sup>48</sup> As the ECJ stated, there is a 'need for the Member States to reconcile the principles and broad scheme of their healthcare system with the requirements arising from the Community freedoms [here, 'the objective of the free movement of patients']...'. [2006] All ER (D) 220 (May), para. 122.

<sup>49</sup> For a fuller analysis of the Directive, see W Sauter, 'Harmonisation in Healthcare: the EU Patients' Rights Directive' TILEC Discussion Paper No. 2011-030 (2011).

<sup>50</sup> Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare (9 March 2011).

the internal market, demonstrates that the objective of many of the Directive's provisions is 'to improve the functioning of the internal market and the free movement of goods, persons and services'.<sup>51</sup> To that end, A1(1) states that the Directive 'provides rules for facilitating the access to safe and high-quality cross-border healthcare and promotes cooperation on healthcare between Member States, in full respect of national competencies in organising and delivering healthcare.' These rules are to be in accordance with the principles established by the ECJ in the 'patient mobility' cases, including *Watts*. Thus, the Directive may be seen as a codifying piece of legislation that gathers together the ECJ principles developed in those cases and expresses them in a way that is both more general and leads to their enhanced practical implementation.

The consequence of this codifying objective is that much of the Directive merely reiterates the principles established by the ECJ in *Watts* (and other cases) and which were set out earlier in this article. Thus, the Directive highlights the ECJ's consistent protection of the right of Member States to limit the reimbursement of cross-border healthcare – and therefore restrict the freedom of movement provisions of the Treaties – for a variety of reasons, amongst which is the ground of 'overriding reasons of general interest'. Such reasons include planning requirements relating to the aim of ensuring sufficient and permanent access to a balanced range of high-quality treatment in the relevant Member State or to the wish to control costs and avoid, as far as possible, any waste of financial, technical and human resources. They also include the objective of maintaining a balanced and medical hospital service open to all in so far as it contributes to the attainment of a high level of health promotion. Sauter notes how the Directive has, in line with the ECJ cases on patient mobility, placed more emphasis on the

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<sup>51</sup> Preamble of the Directive, recital 2.

planning exception for Member States of affiliation (that is, the home Member States of those seeking to obtain treatment abroad) than the original proposal for a Directive drawn up by the Commission.<sup>52</sup> Moreover, the Directive extends the application of this exception to cover Member States of treatment.<sup>53</sup>

It is necessary, however, to be careful not to over-emphasise the role of the planning exception in the context of the Directive. One reason for this is that the exception operates to limit the reimbursement of cross-border healthcare and, thereby, restrict the freedom of movement provisions in the Treaties – not to avoid them completely. As noted, the objective of the Directive is to set out rules by which to improve the functioning of the internal market and the free movement of goods, persons and services, rather than to create mechanisms by which Member States can circumvent these. As the Directive's Preamble makes clear: 'As confirmed by the Court of Justice, neither its special nature nor the way in which it is organised or financed removes healthcare from the ambit of the fundamental principle of the freedom to provide services'.<sup>54</sup> Moreover, the main method of seeking to limit the reimbursement of cross-border healthcare envisaged by the Directive – prior authorisation – creates difficulties for Member States of affiliation who seek to rely on the planning exception. Again, one needs to begin here with the purpose of the provisions relating to prior authorisation in the Directive, which is not, as may have been thought, to shield Member States of affiliation from the Treaty freedoms, but to ensure their facilitation: 'The sole objective of the provisions regarding prior authorisation and reimbursement of healthcare provided in another Member State should be

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<sup>52</sup> Sauter, *op cit.*

<sup>53</sup> See A4(3).

<sup>54</sup> Preamble of the Directive, recital 11.

to enable freedom to provide healthcare for patients and to remove unjustified obstacles to that fundamental freedom within the patient's Member State of affiliation'.<sup>55</sup> Indeed, as prior authorisation has been deemed by the ECJ to constitute a restriction to the free movement of services, the general rule is that Member States of affiliation should not make the reimbursement of the costs of health care received in another Member State subject to prior authorisation, where these costs would have borne by the national health system, had the treatment been received within the Member State of affiliation.

Where a system of prior authorisation is justified on the basis of the planning exception and in place, the foundation for its operation – that is, the grant and refusal of this authorisation in specific cases – does not reside in the 'overriding reasons of general interest' criterion. Rather, the criteria shift to become much more focused on medical and healthcare outcomes and implications, together with the timing of treatment.<sup>56</sup> Three of the criteria revolve around concerns about the safety either of individual patients or the general public as a result of the requested cross-border health care. The final criterion, and the key one for the purpose of the Directive, is the more familiar condition relating to undue delay – can the health care sought be provided within the health system of the Member State of affiliation within a time limit which is medically justifiable, based on an objective medical assessment of the patient's medical condition, the history and probable course of the patient's illness, the degree of the patient's pain and/or the nature of the patient's disability at the time when the request for authorisation was made or renewed?<sup>57</sup> If not, authorisation for the treatment to take place in the Member

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<sup>55</sup> Ibid., recital 35.

<sup>56</sup> The criteria for refusing to grant prior authorisation are set out in A8(6).

<sup>57</sup> A8(5).



State of treatment must, in principle, be granted – unless any of the safety-risk criteria just mentioned are satisfied. It is clear, then, that determinations regarding the refusal of prior authorisation have the same basis in the Directive as they do in the ruling of the ECJ in *Watts* – namely, an objective medical assessment of individual patients; or what was referred to earlier in this article as ‘the individualisation of clinical judgment’. The Directive makes this doubly clear for health systems such as the NHS when it reiterates in its Preamble the point about waiting lists made by the ECJ in *Watts* – that is, that the refusal to grant prior authorisation ‘may not be based on the ground that there are waiting lists on national territory intended to enable the supply of hospital care to be planned and managed on the basis of predetermined general clinical priorities, without carrying out an objective medical assessment’.<sup>58</sup> The result is that, unlike the establishment of a system of prior authorisation – which may be based on the planning exception via ‘overriding reasons of general interest’ (the grounds of which, as Sauter notes, have been generously extended in the Directive) – decisions regarding the grant and refusal of prior authorisation must be based on medical criteria and judgments focused predominantly on the individual. This is important as it is at this grant/refusal stage of prior authorisation that the flow of health care resources abroad and the effective implementation of the free movement rules are determined. The problem is that at the very moment the Member State of affiliation, which does not wish to divert its scarce health care resources to health care providers abroad, might wish to raise the planning exception to prevent such an eventuality, it is prevented from doing so, as the decision is passed over to members of the medical profession and individualised.

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<sup>58</sup> Preamble of the Directive, recital 43.

Insofar as the validity of the key aspects of the *Watts* ruling described earlier is concerned, the Directive has little effect. For, while it gives more prominence and scope to the planning exception as a determinant of the need to establish a system of prior authorisation, it leaves in place the medicalised and individualised nature of the criteria used to determine whether or not prior authorisation is, in fact, to be granted. Crucially, it also confirms that, like A49 EC Treaty [A56 TFEU], the Directive will apply to cross-border health care provided by private, as well as public, health care providers.<sup>59</sup> Moreover, the importance of ensuring that administrative procedures are in place for managing the use of cross-border healthcare and reimbursement of costs is, as in *Watts*, stressed in A9 of the Directive. In particular, decisions by Member States regarding access to cross-border health care and reimbursement of costs must be ‘properly reasoned’ and subject to challenge via judicial review.<sup>60</sup>

## VI. JURIDIFICATION, MEDICALISATION AND THE LIBERALISATION OF HOSPITAL CARE SERVICES

What light can the notions of juridification and medicalisation shed on the liberalisation of hospital care services provided for by the ECJ’s ruling in *Watts*, and the reiteration of its principles in the Directive? That is the question with which the discussion in this section is concerned. The argument will be that juridification and medicalisation combine to provide a useful framework through which to comprehend *Watts* and the Directive – not simply in terms of the facts of that specific case; but, more broadly, as regards their potential implications for

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<sup>59</sup> See Article 1(2): ‘The Directive shall apply to the provision of healthcare to patients, regardless of how it is organised, delivered and financed’; and A3, para. (g): ‘“healthcare provider” means any natural or legal person or any other entity legally providing healthcare on the territory of a Member State’.

<sup>60</sup> A9(4).

the relationship between law and politics in the context of access to health care, and for the role of the welfare state (here represented in the form of the NHS) today *vis-à-vis* the market.

#### A. Expropriation and Depoliticisation

In the first instance, *Watts* can be read as an instance of expropriation. This expropriation amounts to the depoliticisation of the fundamental political issues, questions, and conflicts surrounding the political project of liberalising hospital care services. In other words, these issues, questions, and conflicts (the nature of which were outlined earlier and appeared in parts of the Secretary of State's arguments), become juridified and medicalised – made subject to the legal and the medical, as opposed to the political, system. This can be illustrated by returning to the ECJ's ruling. As noted, whether or not undue delay exists in particular cases is to be measured through the performance of an objective *medical* assessment of the patient's medical condition and his or her particular circumstances, including the degree of pain and the history and probable course of the illness. Should this assessment result in a finding of undue delay, the patient's local primary care trust must, subject to the new safety-risk criteria in A8(6) of the Directive, authorise treatment to take place abroad and refund its cost. The ruling, however, also envisages a similar role for the domestic *court*. Thus, it is for the court undertaking judicial review of refusals to grant authorisation to determine whether the waiting time on the NHS exceeds a medically acceptable period in the light of the patient's particular condition and clinical needs. In order to undertake this judicial review function properly, the court, if it thinks it necessary, must be able to call on 'wholly objective and impartial independent experts' (presumably medical experts). It is important to note that the EU

Patients' Rights Directive does not reverse this depoliticisation; rather, by entrenching those aspects of the *Watts* case, it sustains this expropriation via law and medicine.

Two observations can be made regarding this expropriation of politics, via law and medicine, created by the ECJ in *Watts*. The first is that medical professionals and judges become extremely powerful players in determining both the types of political questions, issues, and conflicts relating to the liberalisation of hospital care services within the EU identified earlier *and* the extent to which this political project materialises in practice. The degree to which NHS resources flow to other EU countries, thereby supporting liberalisation, lies very much in the hands of medics and lawyers. This has implications for the traditional role of domestic courts within the UK when deciding disputed cases involving the allocation of scarce NHS resources – a role that touches centrally on the relationship between law and politics.

When dealing with challenges to decisions made by health authorities or primary care trusts regarding the allocation of scarce health care resources *within* the NHS, judges adopt a restrained approach to their judicial review function.<sup>61</sup> This approach focuses upon ascertaining the lawfulness of these decisions, and the health care policies upon which they are based. The underlying constitutional principle this is meant to reflect is the separation of powers, in which the judiciary confines its role to the policing of public (political) power, rather than its usurpation. There is no question of the courts intervening to determine the direction in which

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<sup>61</sup> As one judge said in an early case: 'It is not for this court, or indeed any court, to substitute its own judgment for the judgment of those who are responsible for the allocation of resources.' *R v. Central Birmingham Health Authority, ex parte Walker* (1987) 3 BMLR 32, at 32, *per* Sir John Donaldson MR. While this restrained approach continues to be adopted in the case of substantive judicial review, where procedural review is concerned, the English courts have become less reluctant to intervene in recent years, as cases like *R v. North West Lancashire HA, ex parte A, D, and G* [2000] 1 WLR 977 and *R (Ann Marie Rogers) v. Swindon Primary Care Trust and the Secretary of State* [2006] EWCA Civ 166 demonstrate.

scarce public health care resources should flow. Here, the legal is clearly separated from the political. As Thomas Poole has noted, the redeeming feature of judicial review lying at the heart of this interpretation of the judicial review role is its '*removed or intermediate* quality', meaning that it 'has as its object the legitimacy of governmental (or public) decision-making', rather than 'fundamental questions of justice and morality'.<sup>62</sup> The importance of this delineation of functions lies in the conviction that judges are not best placed to 'make the final determination in important political matters ... [T]o allow the ultimate decision on the prioritisation of values to rest with the judges smacks of abandoning a democratic system in favour of one layered with aristocracy (the decisions of the few best)'.<sup>63</sup>

The practice of the judiciary in domestic cases involving questions of allocation of health care resources has not escaped critique. Keith Syrett, for instance, has argued that judges should undertake their judicial review function more rigorously, and to much greater effect, than they have done to date.<sup>64</sup> In Syrett's view, courts ought to ensure that those empowered to allocate resources explain clearly, and with the support of concrete evidence, the reasons why they decided to allocate resources as they did. This more rigorous judicial approach would not only render decisions about allocation transparent to both the individuals affected and the broader public; the public understanding of the basis of such decisions facilitated by this would also work to strengthen the legitimacy of those making the decisions. In turn, this would heighten the possibility of democratic debate on the question of health care rationing. This exhortation to judges to do more in the context of judicial review, however, in no way upsets the

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<sup>62</sup> T Poole, 'Questioning Common Law Constitutionalism' (2005) 25 L.S. 142, 161. Emphasis in original. Reference omitted.

<sup>63</sup> *Ibid.*, 162.

<sup>64</sup> Syrett, *op. cit.*

characterisation of the relationship between law and politics described above. Rather, in suggesting that public law can work to enhance the legitimacy of public power, Syrett's argument is consistent with the separation of the legal and the political underpinning this understanding of judicial review. Judges should not be exercising the type of political power involved in determining the flow of scarce public health care resources. They should, rather, police it, and the processes surrounding its exercise, to greater effect – including to the end of enhancing politics and the political.

In respect of patients whose legal challenge is directed towards their wish to obtain NHS treatment that has been denied them, there would seem to be no reason to think that the *Watts* ruling would alter this understanding of the courts' judicial review role. However, in relation to applications by patients seeking to challenge refusals of prior authorisation by their local primary care trust to travel to another EU Member State to receive hospital treatment, the ECJ's ruling in *Watts* collapses this distinction between the legal and the political inherent in the traditional approach to the function of judicial review. This is because it is the domestic court that must determine whether the NHS waiting time for the relevant treatment upon which the refusal is based exceeds a medically acceptable period in the light of the patient's particular condition and clinical needs. This role goes beyond ascertaining the lawfulness of the refusal (and, in the event of a finding of unlawfulness, referring the decision back to the local primary care trust for reconsideration), to ruling on whether there has, in fact, been undue delay. In these circumstances, the allocation of NHS resources will depend upon the nature of this ruling. The result is a shift in the nature of judicial review from one displaying Poole's '*removed or intermediate quality*' to one of '[making] the final determination in important

political matters’ – namely, whether or not scarce NHS resources are taken out of the system, with all the potential consequences and costs (including those of a political nature) this determination entails.

Linked to this constitutional shift in the nature of the relationship between law and politics, the second observation regarding the expropriation of politics facilitated by the ECJ in *Watts* is that the determination of these political matters occurs in a *depoliticised* manner. In other words, these fundamental political matters are not only wrenched from the domain of the political; they are also, in the process, distorted as they become subjected to the medical and legal systems. So, for instance, the issue of whether UK taxpayers’ money should be diverted to health care providers abroad, with the potential consequences for NHS patients, Government finances and health care planning this entails, is converted into a question of the particular clinical needs of individual patients and whether they are enduring undue delay on the NHS. Rendering the issue of travelling to another EU Member State to obtain hospital treatment a matter of clinical and judicial judgment serves to pre-empt any debate amongst, or anticipatory resistance by, citizens concerned about the deployment of NHS resources to the furtherance of the project of developing an EU internal market in hospital care services. The result is an instance of Mathiesen’s ‘silent silencing’ – the ability of law (and in this case medicine) ‘to transform political questions of conflict into apparently neutral, technical and professional questions’.<sup>65</sup> Thus, rather than facilitating the type of democratic debate on health care rationing that Syrett argues ought to be the ultimate outcome of a more rigorous judicial approach to cases involving the allocation of NHS resources, the focus on medical evidence and

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<sup>65</sup> Mathiesen, *op. cit.*, 17.

clinical judgment regarding particular patients' medical conditions and clinical histories resulting from *Watts* and the Directive ensures that the function of judicial review will be to close this possibility down.

#### B. Expansion of Law, the NHS and Ambivalence

As well as expropriation, *Watts* and the Directive can be perceived through the lens of juridification in the sense of Habermas's definition of an expansion of law. This occurs through the application of EU law – specifically the free movement rules – for the first time to the issue of accessing NHS resources for the purpose of receiving hospital treatment. A new legal basis is therefore established for obtaining access to these resources. Of course, in order for this EU legal provision to be effective, it must, in cases where a system of prior authorisation is in place, first be established that the individual is enduring undue delay. Assuming, however, that this can be proved, EU law effectively creates a new legal right to access NHS resources for the purpose of obtaining hospital treatment – something that has not been a part of domestic law in the UK.

Like Habermas's observations in respect of the legal rights to the welfare state's monetary benefits, this new EU legal entitlement to access hospital care outside one's own Member State, and to be reimbursed for it, might be thought to have important consequences. However, unlike those Habermas identifies in his analysis of the welfare state – the contradictory freedom-denying effect of legal entitlements designed to guarantee freedom, and the impact on communities of wrenching social issues from their social and historical



origins<sup>66</sup> – the locus of the effects of EU law, it is suggested, is to be found elsewhere. Of course, the political implications of EU law here – discussed above – clearly represent one set of important consequences. There are, however, others too. In particular, one effect might be thought to occur not at the level of the community or lifeworld *per se*, but in relation to that welfare institution with which we are concerned here – namely, the NHS. That is, there exists a real danger that the rights of the individual will compromise the solidary principle upon which the NHS was founded. In other words, the right to access hospital care treatment in another EU Member State may, as noted earlier, mean those in dire need of an operation, but who are unable, for instance, to travel abroad, are not treated (or not treated timeously), as funds are diverted to reimburse those taking advantage of EU law. Of course, this is exactly the problem Newdick has addressed in some of his recent work.<sup>67</sup> What Habermas directs us to, though, is the importance of the legal basis of such a potential consequence. For the threat to the NHS's solidary basis results not, to use Habermas's words, as a side effect of juridification but from the form of juridification itself. It is the novel application of an individual legal entitlement within EU law to an aspect of the welfare state where no right has previously existed that endangers, not the freedom of the beneficiaries that Habermas describes, but the community – solidary – ethos upon which the NHS was founded. To put it another way, the juridification evident in *Watts* and the new Directive, that via the free movement rules creates legal subjects who pursue their private interests, fails to pay due regard to the social basis of the NHS, with its planned waiting lists and objective of an equitable distribution of resources.

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<sup>66</sup> It is worth noting that one of the key health care policies of recent UK governments has been an emphasis on devolving health care to individuals and their families, thereby seeking to alter the perception that the NHS is the only legitimate provider of health care. For the latest affirmation of this policy, see Department of Health, *op. cit.*

<sup>67</sup> See Newdick, 'Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity', *op. cit.*

While this is true, like Habermas's understanding of juridification, it is suggested that this new EU legal entitlement is ambivalent. The nature of this ambivalence in the current context, however, differs from that described by Habermas. As we saw earlier, for Habermas the ambivalence of the legal entitlement to monetary benefits within the welfare state lay in its simultaneous freedom-guaranteeing and freedom-reducing characteristics. Insofar as EU law is concerned, it is suggested that the ambivalence resides in its effect on the welfare state, rather than the individual. For while in one sense the individual nature of the legal entitlement under EU law fails to respect the solidary nature of the NHS, it nevertheless depends upon this welfare institution's continued existence for its viability. The objective of creating and maintaining an internal market in hospital care services in which individuals exercise their free movement rights to travel to other EU Member States, relies upon the resources of welfare state institutions. Liberalisation has dependencies. Thus, while being contrary to the solidary basis of the NHS, the practical implementation of this EU legal entitlement comes, like the beneficiaries Habermas describes, to depend on the welfare state and public resources in a more general sense. The latter describes the importance of what might be called *public wealth* to the success of the free movement provisions. Of course, this public wealth has a financial component – the publicly funded resources allocated to the NHS by central Government. But it might also be thought to encompass a non-financial public resource or wealth too – for instance, the publicly funded doctors and judges whose responsibility it is to conduct the necessary objective medical assessments of individual patients' conditions with a view to establishing the existence of undue delay. EU law therefore ensures that the skill, time, and labour of these public servants will function as core features of the development of the internal

market in hospital care services – part of which has the potential to benefit commercial providers of health care around the EU.<sup>68</sup>

This ambivalent effect of juridification arising from EU law therefore enables the identification of the types of foundations that are necessary for both the establishment of an internal market in hospital care services within the EU and an increased role for private health care providers. *That* these are possible consequences flowing from the *Watts* ruling does not seem to be in doubt. Szyszczak argues that the ECJ has sought to ‘maximise free movement rights [those legal rights underlying the liberalisation of access to hospital care services] and give them greater priority as *market opening legal tools*’.<sup>69</sup> Moreover, she suggests that free movement rules tend to assume, rather than question, ‘that services relating to a range of healthcare provision are ‘economic’’.<sup>70</sup> Some evidence exists to suggest that this has the potential to be reflected in practice. For instance, in their analysis of the actual impact of ECJ rulings on patient mobility on national health care systems within the EU, Baeten et al describe the possibility of these rulings being used either by domestic health care providers or governments to increase the role of commercial providers of health care in the treatment of patients.<sup>71</sup> This would allow governments to contract out the provision of publicly funded health care to private providers, thereby allowing those enduring undue delay within the NHS to be treated domestically, rather than having to travel abroad. Similarly, the authors note that while the UK Department of

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<sup>68</sup> For a brief discussion of how the ECJ’s judgments on the free movement of patients may facilitate a greater role for private providers of publicly funded health care *within the UK*, see G Davies, ‘The Effect of Mrs Watts’ Trip to France on the National Health Service’ (2007) 18 *King’s College Law Journal* 158, 166.

<sup>69</sup> Szyszczak, ‘Legal Tools in the Liberalisation of Welfare Markets’, *op. cit.*, 285. Emphasis added.

<sup>70</sup> *Ibid.*, 286. Reference omitted.

<sup>71</sup> R Baeten et al, *The Europeanisation of National Health Care Systems: Creative Adaptation in the Shadow of Patient Mobility Case Law* (Brussels: OSE Paper Series, 2010). The authors refer to Belgium and the UK in this respect.

Health Guidance issued in the light of *Watts* speaks of the NHS allowing for planned hospital care abroad after prior authorisation, it does not rule out the possibility that patients may be treated outside of the public health care system of the country of treatment – that is, by for-profit providers. The Guidance suggests that, in these circumstances, the free movement provisions of the Treaty will be in the interest of the patient. This supports the market-opening possibilities of the *Watts* ruling and, now, of the Directive too.

Analysing the legal foundation of these possibilities therefore helps to shed light on the various elements that are involved in supporting the creation of the internal market in hospital care services and the potential for an increased role for private health care providers. In particular, the ambivalent nature of the juridification arising from EU law raises questions about characterisations of the *Watts* case that detect in it a conflict or tension between the liberalisation of EU health care services (the market) and the social nature of the right established for the purpose of accessing these services (the social). Davies, for instance, has argued that the case discloses a theme of ‘the gradual development of social rights [the near right to adequate medical care] in Community law, in an attempt to balance the claimed market bias.’<sup>72</sup> As noted, there is no doubt that *Watts*, and now the Directive, creates a conditional legal right to access hospital care in other EU Member States. But this social-market interpretative framework, which, through its idea of the need to balance these two elements, views them as somehow in conflict, is in need of critical analysis. In one sense, this is because the social right in this context does not function as a counter-weight to ‘market bias’, but, rather, as a necessary feature of the internal market’s development in the field of EU hospital

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<sup>72</sup> Davies, *op. cit.*, 166.

care provision. Giving patients rights to access hospital care services outside of their own countries is essential as a means of creating increased demand for such services within the EU and the potential for a greater role for commercial providers in the provision of these services – a prerequisite for the establishment of competitive markets.

In another sense, and as already noted, the social-market distinction fails to capture the indispensability of a welfare institution like the NHS to the success of a market in hospital care services. As no EU health care budget from which funds can be drawn exists, patients must be funded by their domestic health care systems to travel abroad, thereby enabling the establishment of the internal market. Indeed, as hinted at above, it might be better to think through the establishment of markets and the potential for greater commercial involvement in this area as being grounded in what might be called the public, rather than the social. For this would highlight the public foundations of these effects of EU law – NHS funds to be sure, but also the legal and medical systems and their funds and servants. It would also assist in identifying the inextricable link between the public and the private disclosed by EU law in this area. For rather than setting in train an instance of the much critiqued wholesale privatisation of public goods and services – that is, the conversion of those goods and services into private ones by means of dispossession – EU law rather puts in place the mechanisms required to facilitate the periodic extraction of resources from a continuing system of public wealth. The public resources and services of the NHS are not in any way privatised as a result of EU law (as noted earlier, Member States are to retain the right to determine the nature of their health care systems); instead, their continuation as public goods might be thought to be crucial to ensure the presence of a secure, large fund from which money can periodically be extracted to

support the EU internal market in hospital care services, including, potentially at least, the profits of commercial health care providers. Relying on the private resources of individuals to sustain this market and those types of provider, especially given the current financial predicament of many European Member States, would not be a viable option. And it is this financial component of the flow of public wealth which is to be organised, or managed, by its other, institutional, facet – the public systems and servants of law and medicine. What the ambivalent nature of the juridification to be found here helps to reveal, then, is the structured nature of liberalisation – the latter’s manifestation being the development of the EU’s internal market in hospital care services, together with the prospect for increased commercial involvement in its operation. Like all markets, this market does not spring up from nowhere. Rather, its creation and sustenance requires, and depends upon, structures and institutional bases.<sup>73</sup> In the current context, these take the form of law, medicine, and the public funds allocated to the NHS.

### C. Juridification, Medicalisation and Bureaucracy

This brings us to a final observation regarding the relationship between juridification, medicalisation, and EU law on patient mobility. It was noted earlier in the article that a common theme of Habermas’s juridification and McLean’s and Illich’s understandings of medicalisation was the bureaucratic nature of the welfare state. Among other things, their work can be viewed as a critique of the welfare state for its alleged technocratic and scientific

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<sup>73</sup> For the importance of structures generally to the creation and operation of markets, see, for example, D Harvey, *A Brief History of Neoliberalism* (Oxford: OUP, 2005); L Panitch and M Konings, ‘Myths of Neoliberal Deregulation’ (2009) 57 *New Left Review*, 67-83; P Bourdieu, *The Social Structures of the Economy* (Cambridge: Polity, 2005); and E Christodoulidis, ‘The Politics of Liquid Modernity: Polanyi and Bauman on Commodification and Fluidity’, in J Přibáň (ed), *Liquid Society and Its Law* (Aldershot: Ashgate, 2007), 101.

nature. Specifically, the charge levelled at the medicine and law of the welfare state is its denial of individual power and freedom as a result of the welfare state's wrenching of a variety of issues (including health, illness, and old age) from their social conditions of origin and their transfer to the workings of the bureaucratic state. Habermas sums this up when he says that 'legalized social intervention' transfers such issues 'over to media such as power and money'.

In the light of *Watts* and the Directive, it is suggested that it is necessary partially to reformulate this understanding of juridification and medicalisation. For while it is true that the exercise of the legal right to access hospital care within the EU depends on the clinical assessment of an individual's medical condition by the medical and legal professions, from the foregoing discussion the ends to which this is directed are not the empowerment of professionals and the efficient functioning of the bureaucratic welfare state *per se*. They are, instead, and on the one hand, the empowerment of individuals, and on the other, the development of the internal market and, at least potentially, the facilitation of an increased role for commercial health care providers in the provision of publicly funded health care. Of course, these alternative ends do not negate the need for an efficiently functioning welfare state and the public servants and institutions entrusted with its management; indeed, quite the opposite – as noted, the medical and legal systems, together with NHS funds, will be integral in contributing to the attainment of these objectives. Moreover, the 'power and money' Habermas refers to in his analysis of juridification and the welfare state cannot be confined to describing the monetary benefits distributed by the welfare state or the pursuit of its administrative ends; they must, in light of the relevant EU law, instead be rethought and

extended to include the power of liberalisation and markets, and the profit margins of commercial health care providers.<sup>74</sup>

The implications of this for the critique of medicalisation undertaken by McLean and Illich are mixed. Thus, on the one hand, law does, through the application of the free movement provisions, empower patients by giving them a legal entitlement to access hospital treatment within the EU if they are enduring undue delay within the NHS. By paying due regard to the individual's particular medical circumstances, rather than the financial consequences of treatment abroad for the management of the NHS, EU law addresses the de-individualising effect of medicalisation critiqued by Illich and McLean. On the other hand, however, this individualisation constitutes a mixed blessing as it remains tied up with the medical and dependent upon the clinical assessments of members of the medical profession. Perhaps the key observation to be made about the implications of EU law on patient mobility for the critiques of medicalisation advanced by Illich and McLean, however, is not so much the degree to which this law addresses these authors' specific concerns, but what it reveals about the limitations of their ideas of medicalisation. For as conceived by Illich and McLean, medicalisation is intimately connected to morality and ethics. The critique of medicine's de-individualising characteristics targets, centrally, the failure to leave individuals alone so that they can make decisions about health and illness based on their own value systems, and establish their own methods for coping with the suffering and pain accompanying illness. It is the denial of civil liberty that is central to this understanding of medicalisation. The law, for its

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<sup>74</sup> For an argument that Habermas's analysis of juridification needs to be extended so as to incorporate the importance today of the economic ends of financial institutions and their shareholders, see S Veitch, 'Legal Right and Political Amnesia' in K Nuotio (ed), *Europe in Search of 'Meaning and Purpose'* (Helsinki: University of Helsinki, 2004), 89.



part, is found wanting for its complicity in this state of affairs, as it fails to deploy the discourse of rights as a means of reversing the liberty-denying aspect of medicalisation.

While important, recent EU law on patient mobility demands that we supplement this notion of medicalisation by identifying a critical link between medicine, markets, liberalisation, and the potential for a greater role for commercial health care providers in the provision of publicly funded hospital care services. Here, it is not the medicine-ethics-patient liberty link that is so prominent, as the relations between medicine, law, and the economic. And, in line with the discussion of the bureaucratic welfare state above, it is necessary to extend Illich's analysis of the bureaucratic nature of medicalisation beyond the liberty-denying features he identifies so as to incorporate an analysis of the relationship between medicine, the welfare state, and the types of economic ends which, it has been argued here, are a key feature of EU law in this area. What role does medicalisation play in facilitating those types of ends? How is medicalisation's bureaucratic or technical nature bound up with promoting a market in EU hospital care services? What is the relation of law to medicalisation where economic issues, as opposed to ethical-liberal ones, are concerned? In short, in order to think through the nature of contemporary economic and legal developments around medicine and health care, it is suggested that we need to reflect anew on, and update our understanding of, the relationship between medicalisation and law – a debate that has been of such importance within medical law historically.

## VII. CONCLUSION

EU law on patient mobility is designed to contribute to the liberalisation of the provision, and receipt, of health care services within the EU. More specifically, it draws the NHS into this pursuit of the objective of liberalisation and confirms that its resources – financial and human – can be deployed to further it. It has been argued that the architecture the ECJ, and now the Directive, have put in place to facilitate the NHS's involvement masks or depoliticises the types of fundamental political issues outlined in this article. This occurs by converting these issues into a technical matter revolving around the assessment of the clinical conditions and needs of individual patients, and a judgment as to whether they are suffering undue delay within the NHS. Clearly, medical professionals have a key role to play here. But it is the law, too, specifically public law, via an extension of the judicial review function of domestic courts in those cases where patients have been refused prior authorisation to receive hospital treatment abroad, that becomes involved in determining the presence of undue delay – and thus in the depoliticisation this entails. The result is an ironic one: the furtherance of the political project of liberalising access to EU health care services is founded upon depoliticising mechanisms. It has been argued that this application of EU law has additional, and broader, ramifications – especially for understandings about the relationship between the welfare state and markets, and how contemporary law and medicine are involved in this.

The analytical framework of juridification and medicalisation has been deployed in an effort to think through the nature of these effects of recent UE law on patient mobility. What emerges from the analysis is not only how those notions may help in undertaking such a reflection, but also how juridification and medicalisation – developed by the authors identified in this article as means, *inter alia*, of critiquing the freedom-denying and bureaucratic characteristics of the

welfare state – may, as concepts, require updating and reformulating so as to capture contemporary legal developments as they relate to the medical and health care spheres. In particular, it is the economic aspect of those developments and its impact on traditional understandings of the role of the welfare state (the NHS) and what has here been called public wealth, that the notions of juridification and medicalisation must seek to explain today.